Urinary Voiding Dysfunction

THE UROGYNAECOLOGICAL SOCIETY OF AUSTRALASIA

What is voiding dysfunction?
Voiding dysfunction occurs when the bladder does not empty completely, meaning there is always more than 100–150mls of urine left within the bladder. A voiding dysfunction can be temporary, for example after surgery for prolapse or incontinence. It can occur very suddenly or develop slowly over several years.

What are the symptoms?
Women who suffer from a voiding dysfunction may experience some or all of the following:

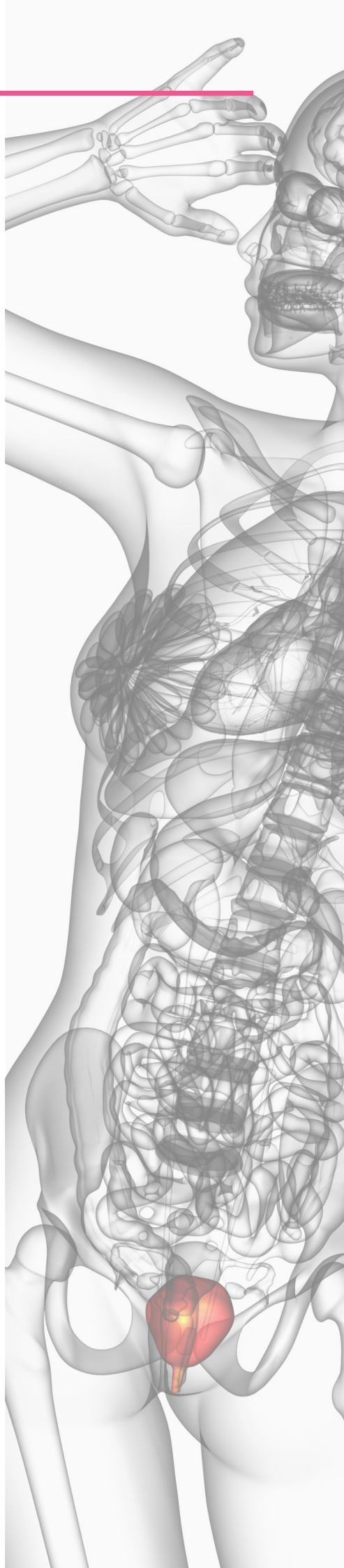
- Bladder does not feel empty after passing urine
- Urine flow is very slow or is start-stop (intermittent)
- Straining with the abdominal muscles to empty the bladder
- Passing small amounts of urine frequently, but never feeling the bladder is empty .
- No sensation of needing to pass urine.
- Repeated urinary tract infections.

Why does a voiding dysfunction occur?
For the bladder to empty properly, the pelvic floor muscle needs to relax, the muscle within the urethra needs to relax and then the bladder muscle (detrusor muscle) needs to contract to squeeze the urine out of the bladder.

There are 2 main reasons why women do not empty their bladders completely:

1. The bladder muscle contraction is not strong enough (underactive detrusor) as seen in Figure D. This can occur due to:
   a. Natural ageing process
   b. Diabetes
   c. Neurological conditions (such as multiple sclerosis or a spinal cord injury)
   d. Some medications.

2. A blockage (obstruction) along the urinary tract. This blockage can occur due to:
   a. A large prolapse “kinking” the urethra (Figure C)
   b. Scarring or a lump inside the urethra
   c. Something pressing on the urethra (such as a fibroid)
   d. Continence tape that is too tight (Figure B)
   e. Spasm in the urethral or pelvic floor muscle.



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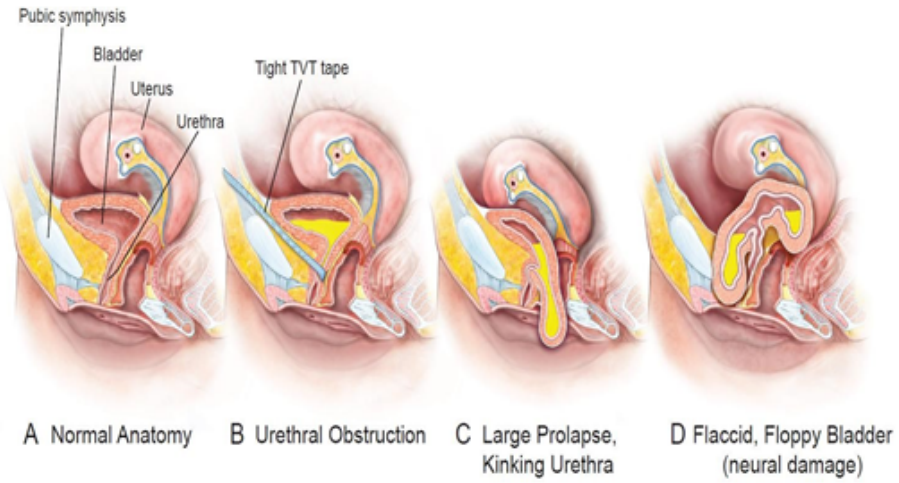
How do we diagnose a voiding dysfunction?

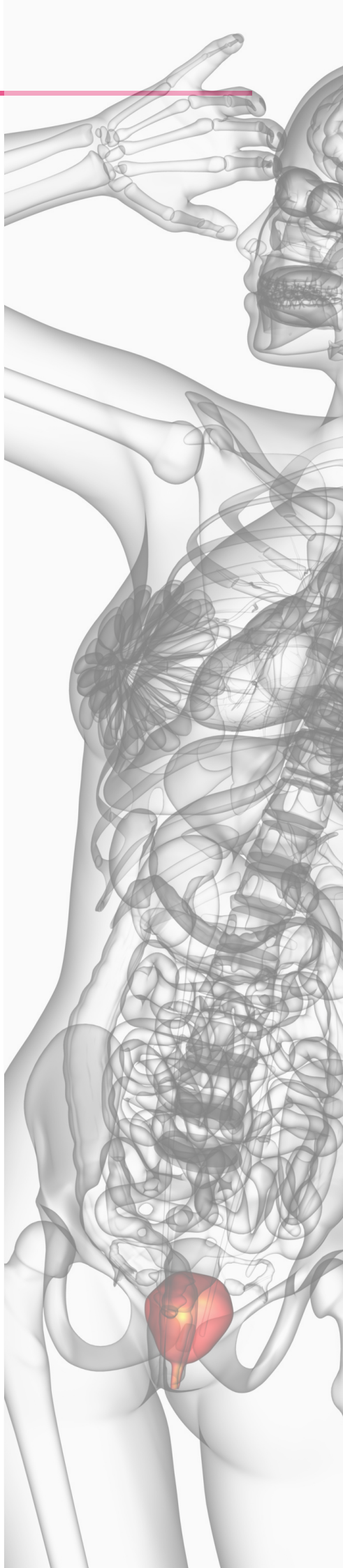
Your gynaecologist will ask about the history of your problem and perform an examination to rule out any obvious causes, such as a prolapse. To check whether you have emptied your bladder, your gynaecologist will use a bladder scanner to check how much urine is left in your bladder. You will be tested for a bladder infection, as this can cause similar symptoms, or may occur if the bladder does not empty well. Your gynaecologist may arrange further bladder testing (urodynamic studies – UGSA Patient Information Sheet with more details) which may help to explain the reason for your symptoms. It may be necessary to have a look inside your bladder with a small camera (cystoscopy – UGSA Patient Information Sheet available from our website). You may require an ultrasound scan to evaluate for other possible causes, such as fibroids or cysts, as well as to review the kidneys.

How do we treat a voiding dysfunction?

If the bladder does not empty completely, this can lead to bladder or kidney infections and can also adversely affect how the kidneys function. Keeping the bladder empty reduces these risks.

Women can be taught to empty their bladders using a small catheter that is placed into the bladder. This is called clean intermittent self-catheterisation (CISC) and is usually supervised by your gynaecologist. It is important to always try to pass urine into the toilet first, before performing CISC, so that your bladder does not become “lazy”. CISC can be ceased when the volume of urine emptied with the catheter (called the residual) is consistently low.www.continence.org.au – information on funding and care of catheters.





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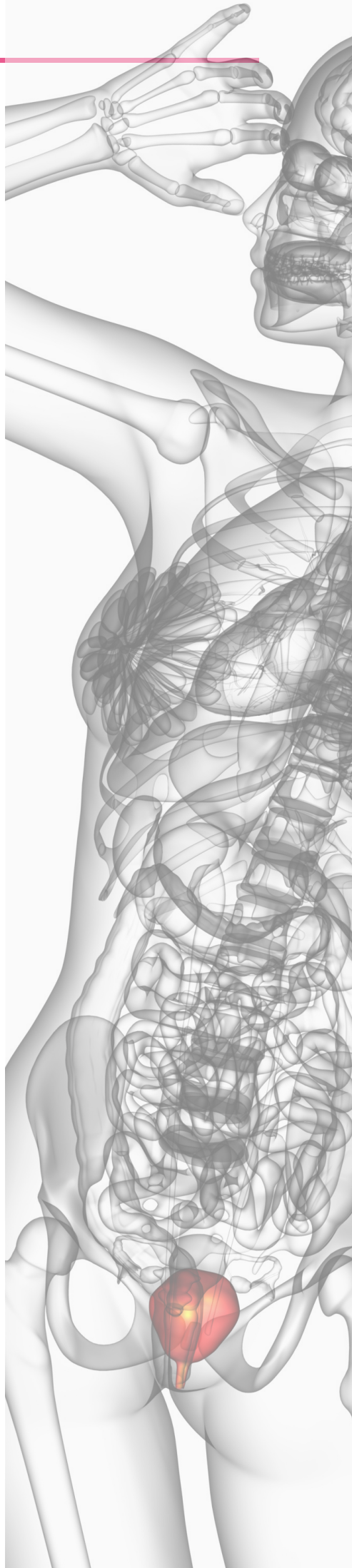
Antibiotics may be used to decrease the risk of further bladder infections while CISC is being performed. Women who are unable or unwilling to perform CISC, will be treated with a permanent catheter inserted either through the urethra (called an Indwelling catheter or IDC) or through the abdomen (called a suprapubic catheter).

If a specific cause for the voiding dysfunction has been identified, this will need to be addressed. Women with prolapse can be offered a pessary or surgery (see our Patient Information Sheet on treatment of prolapse). A continence tape that is too tight should be divided – this will often improve the voiding dysfunction. If there is a spasm in the pelvic floor muscle, it may be helpful to see a physiotherapist to learn relaxation exercises and healthy toileting habits. Some women will have to use catheters permanently. In these instances, CISC is preferable to an IDC.

Where can I get more information?
www.ugsa.com.au – Patient Information Sheets on prolapse, Overactive Bladder (contains information on funding for continence aids), Urodynamic studies, Cystoscopy.



This statement has been developed by the Urogynaecological Society of Australasia (UGSA).